SUNRISE MEDCARE CENTER

80 Wilson Blvd. S. Unit #11 Naples, Florida 34117

PHONE: (239) 208 – 5390 | **ONLINE**: SunriseMedcareNaples.com

IDENTIFYING INFORMATION

First Name:	Middle Name:	Last Name:
Gender:	Date of Birth (m/d/yyyy) :	Social Security #:

CONTACT INFORMATION

Address Line 1:		Address Line 2:
City:	State:	Zip:
E-Mail:	Home Phone:	Mobile Phone:

DEMOGRAPHICS

Ethnicity:	Preferred Language:	Race:
Non-Hispanic Hispanic		

OTHER INFORMATION

Occupation:	Employer:	Employer Phone:
Emergency Contact:	Emergency Phone:	Full Time Naples:
		Yes No

PATIENT INSURANCE

Insurance Company:	Policy No.:	Group No.:
Insurance Company:	Policy No.:	Group No.:

ACKNOWLEDGEMENT OF NOTICEOF PRIVACY PRACTICES

I hereby give permission to Dr. Alfredo Gonzalez Vergara, MD and associates of Sunrise Medcare Center to administer treatment and to perform such procedures, tests, labs as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account and a collection agency will be employed to enforce such. Furthermore, I have read and signed the financial responsibility form and understand the financial policy of Sunrise Medcare Center. This is a lifetime signature. As our physicians are only fluent in English and Spanish, it is the responsibility of the patient to provide an interpreter over the age of 18 if the patient will be unable to speak with and understand the physicians. This is necessary for us to render medical care and for the protection of the patient. Privacy and Information Protection Policy Our office utilizes a HIPAA compliant Electronic Medical Record Storage system. All data collected on this form is strictly used for insurance claim purposes and never shared with outside sources. All information not stored in the secured electronic storage format are shredded and disposed of properly. By signing below, you are acknowledging that you have either received a copy of our Privacy Policy or have been given access to a copy to review.

Signature:		Date (m/d/yyyy) :	

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PATIENT ASSESSMENT

IDENTIFYING INFORMATION

First Name:	Middle Name:	Last Name:

FAMILY HISTORY

Father: Living Deceased

Illnesses: __________

Mother: Living Deceased

Illnesses: __________

Brother(s): How many Living: ____ How many Deceased: ____

Illnesses: __________

Sister(s): How many Living: ____ How many Deceased: ____

Illnesses: __________

SOCIAL HISTORY

Occupation __________

Marital Status ☐ Single ☐ Married ☐ Widowed Divorced/ Year ☐

(Number of Children) ☐ Smoke? ☐ Yes ☐ No If yes, how many packs per day? ☐

Frequency of exercise per week? __________

Do you Drink Alcohol? ☐ Yes ☐ No If yes, how much per week? ☐

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Please check the boxes below for any problems in any designated areas. Otherwise check the normal box.

GENERAL		CARDIAC		GASTROINTESTINAL	
	Normal		**Normal**		**Normal**
	Fever		Pacemaker		Nausea / Vomiting / Diarrhea
	Weight Change		Defibrillator		Colon Polyp or Cancer
	Night Sweats		Bypass Surgery		Irritable Bowel Disease
	Chills		High Blood Pressure		Poor Appetite
	Loss of Sleep/ Fatigue		Heart Disease		Hiatal Hernia or Reflux
BREAST			Poor Circulation		Ulcer
	Normal		Heart Attack		Liver Disease
	Lump	**IMMUNESYSTEM**			Abdominal Pain
	Pain		**Normal**		Hernia
	Nipple Discharge		Previous / Current Cancer		Rectal Bleeding / Hemorrhoids
	Infection		TYPE:	**HEMOTOLOGICAL / LYMPHATIC**	
INFECTIOUSDISEASES			Allergies		**Normal**
	Normal	**PULMONARY**			Bleeding Disorder
	HIV / AIDS		**Normal**		Blood Clots
	Tuberculosis		Cough / Sputum		Swollen Lymph Nodes
	Hepatitis A		Bronchitis		Anemia
	Hepatitis B		Asthma		Blood Transfusions
	Hepatitis C		Shortness of Breath	**HEENT**	
	STD		Pneumonia		**Normal**
	MRSA	**DENTAL**			Hearing Loss / Hearing Aid
GU			**Normal**		Ear Infection
	Normal		Dentures / Gum Disease		Sinus Problems / Runny Nose
	Kidney Disease / Kidney Stone		Other		Nose Bleed

	Prostate	**MUSCULOSKELETAL**			Hoarseness / Sore Throat
	Blood in Urine		**Normal**		Blurred or Double Vision
	Difficulty Urinating		Joint Pain / Arthritis		Glasses or Contacts
	Incontinence		Other		Glaucoma or Retinopathy
NEUROLOGICAL		**ENDOCRINE**		**SKIN**	
	Normal		**Normal**		**Normal**
	Stroke / Paralysis / Seizure		Diabetes		Rash / Bruise Easily
	Dizziness / Weakness / Fainting		Thyroid Disease		Cancer
	Headaches		High Cholesterol		Abnormal Moles
	Alzheimer's				
OB-GYN					
	Normal				
	Currently Pregnant		Trying to Conceive		Breast Fed
	Menopause		Hormone Therapy		Family History of Breast Cancer
Date of 1st Period:			Date of 1st Pregnancy:		

ADDITIONAL PAST MEDICAL HISTORY - MEDICAL CONDITIONS OR HOSPITALIZATIONS:

SURGERIES- PLEASE LIST PROCEDURE(S) AND DATE(S):

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MEDICATIONS YOU CURRENTLY TAKE (PRESCRIPTION, "OVER THE COUNTER" AND HERBAL):

Name of Medicine	Dosage	Frequency	Name of Medicine	Dosage	Frequency

ANY ALLERGIES TO MEDICATIONS? If yes, please list medication(s) and reaction(s).

PHARMACY INFORMATION

Phone Number:

Address:

PREVENTION (COLONOSCOPY, MAMMOGRAM, PAP SMEAR, LIPID PANEL, ETC.)

Colonoscopy ☐ No ☐ Yes, dates

Cholesterol ☐ No ☐ Yes, dates

Bone Density ☐ No ☐ Yes, dates

Pap Smear ☐ No ☐ Yes, dates

Mammogram ☐ No ☐ Yes, dates

Others

Signature	**Date (m/ d/ yyyy)**

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FINANCIAL POLICY

We would like to thank you for choosing Dr. Alfredo Gonzalez Vergara,MD as your healthcare provider. Doctor is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to our services.

For Our Patients with Medical Insurance Benefits: We participate in most major health plans. We have contracts with many insurance companies and government agencies including Medicare. Our business office will submit claims as a courtesy for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please bring your insurance card with you at the time of your appointment. If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage. If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

Co-Payments: Your insurance company may require us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, debit card or credit card payments. If you do not have your co-payment your appointment may be rescheduled.Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you and may be collected at the time of visit.

Waiver of Patient Responsibility: It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's financial hardship policy.

Non-Covered and Out of Network Services: Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

For Our Patients with No Medical Insurance (Self Pay): If you do not have group or individual medical insurance, payment in full for all professional services is expected at the time of your visit. Please note, we offer discounted fees for patients without health insurance.

Non-Payment: All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, will be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice.

Signature:	Date (m/d/yyyy) :

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Authorization to Obtain Medical Record Information

PATIENT INFORMATION

Patient Name:	Birth Date (m/ d/ yyyy):	Gender:	Phone:
Address:	City:	State:	Zip Code:

INFORMATION TO BERELEASED

	Clinical Medical Record		Billing Information		Test Results

RECORDSRELEASED FROM:

Name: (Health Facility, Provider)			
Phone Number:	Fax Number:		
Address:	City:	State:	Zip Code:

RECORDSRELEASED TO:

Name of Recipient:			
Dr. Alfredo Gonzalez Vergara, M.D. ATTENTION: MEDICALRECORDS			
Phone Number:	Fax Number:		
(239) 208 - 5390	(239) 302 - 6813		
Address:	City:	State:	Zip Code:
80 WILSON BLVD. SOUTHSUITE11	NAPLES	FLORIDA	34117

ACKNOWLEDGEMENT

If we are requesting this Authorization from you for use and disclosure or to allow another healthcare provider or health
plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of the signed authorization.
- You may inspect a copy of the protected health information to be disclosed.
- You may refuse to sign this authorization.
- We will provide you a copy of the authorization up on request.
- You will have the right to revoke this authorization at any time provided you do so in writing.
- This authorization will expire only upon receiving written notification from me

Signature:	Date (m/ d/ yyyy):
Print Name:	

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Authorization to Release Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

This authorization will expire only upon receiving written notification from me

I authorize Dr. Alfredo Gonzalez Vergara to request or disclose (release) the following information from medical records of:

Patient Name:	Date of Birth:	Phone:	Medical Record No:
Address:	City:	State:	Zip Code:

Covering the period(s) of health care (select only one):

	All past and future dates		All future dates
	All past dates		From to

Information to be disclosed:

	Complete health record(s), **including** all images (x-rays, photographs, etc.)		Complete health record(s), **excluding** all images
	Other:		

OR Select from the following (check as many as apply):

	Discharge Summary		Consultation Reports		Photography, video tapes, digital or other images
	Progress Notes		X-ray reports		Treatment for alcohol and/ or drug abuse
	History and Physical Examination		Psychotherapy Notes		Mental health care or services
	Laboratory Tests				
	AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection				

Signature:	Date (m/ d/ yyyy) :
Name:	

This information is to be disclosed to the following individual or entity:

Name:			
Address:	City:	State:	Zip Code:

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Notice of Privacy Practices

Effective date: December 1, 2021

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Office Manager c/o Dr. Alfredo Gonzalez Vergara, M.D., 80 Wilson Blvd. S. Unit #11, Naples, Florida 34117.
Phone: (239) 208 - 5390 or **Online**: SunriseMedcareNaples.com

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice ' including, but not limited to, our doctors and nurses ' may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Optional Release of information to family/ friends. Our practice may release your PHI to a friend or family member that is
involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or locallaw.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or
- authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/ locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

A. The use or disclosure involves no more than a minimal risk to your privacy based on the following:
   i. an adequate plan to protect the identifiers from improper use and disclosure;
   ii. an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
   iii. adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

B. The research could not practicably be conducted without the waiver,

C. The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/ or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the contact as listed in **Section B** of this document specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the contact as listed in **Section B** of this document. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the contact as listed in **Section B** of this document in order to inspect and/ or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/ or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the contact as listed in **Section B** of this document. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting you request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures· All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented ' for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the contact as listed in **Section B** of this document· All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, see the contact information as listed in **Section B** of this document.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing. You will not be penalized for filing a complaint. To file a complaint with our practice, see the contact information as listed in **Section B** of this document.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please see the contact information as listed in **Section B** of this document.

Signature:	Date (m/ d/ yyyy) :